FOR OHF USE

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0038711

Facility Name: Embassy Care Center, Inc.

Address: 555 West Kahler Road (Number) Wilmington (City) 60481 (Zip Code)

County: Will

Telephone Number: (815) 476-7931 **Fax #** (815) 476-7939

IDPA ID Number: 36-3863655-001

Date of Initial License for Current Owners: 02/01/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Bob Kagda **Telephone Number:** (847)-675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) Bob Kagda, Partner

(Firm Name & Address) Krupnick, Bokor, Kagda & Brooks, Ltd. 3750 W. Devon Ave. Lincolnwood, Il 60712-1124

(Telephone) (847)-675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	80	Skilled (SNF)	80	29,200	1
2		Skilled Pediatric (SNF/PED)			2
3	91	Intermediate (ICF)	91	33,215	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	171	TOTALS	171	62,415	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	539		2,701	3,240	8
9	SNF/PED					9
10	ICF	30,843	8,317		39,160	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,382	8,317	2,701	42,400	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.93%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 02/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2/1/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 16 and days of care provided 2,256

Medicare Intermediary Administar

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/05 Fiscal Year: 12/05

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	219,368	8,690	6,172	234,230		234,230		234,230			1
2	Food Purchase		183,430		183,430	(22,867)	160,563	(357)	160,206			2
3	Housekeeping	146,195	38,571		184,766		184,766		184,766			3
4	Laundry	52,829	9,502		62,331		62,331		62,331			4
5	Heat and Other Utilities			117,363	117,363		117,363	4,552	121,915			5
6	Maintenance	29,067	7,436	49,486	85,989		85,989	11,494	97,483			6
7	Other (specify):*											7
8	**TOTAL General Services**	447,459	247,629	173,021	868,109	(22,867)	845,242	15,689	860,931			8
	B. Health Care and Programs											
9	Medical Director			5,700	5,700		5,700		5,700			9
10	Nursing and Medical Records	1,178,793	70,544	226,530	1,475,867		1,475,867	(110)	1,475,757			10
10a	Therapy	62,386	401	17,070	79,857		79,857		79,857			10a
11	Activities	98,882	1,927		100,809		100,809		100,809			11
12	Social Services	77,600		6,753	84,353		84,353		84,353			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,417,661	72,872	256,053	1,746,586		1,746,586	(110)	1,746,476			16
	C. General Administration											
17	Administrative	94,390		349,042	443,432		443,432	(249,442)	193,990			17
18	Directors Fees											18
19	Professional Services			50,759	50,759		50,759	6,065	56,824			19
20	Dues, Fees, Subscriptions & Promotions			9,005	9,005		9,005	(208)	8,797			20
21	Clerical & General Office Expenses	132,646	21,603	50,260	204,509		204,509	123,205	327,714			21
22	Employee Benefits & Payroll Taxes			326,592	326,592	22,867	349,459	40,752	390,211			22
23	Inservice Training & Education											23
24	Travel and Seminar			308	308		308		308			24
25	Other Admin. Staff Transportation			35,404	35,404		35,404	(29,269)	6,135			25
26	Insurance-Prop.Liab.Malpractice			174,672	174,672		174,672	4,144	178,816			26
27	Other (specify):*											27
28	**TOTAL General Administration**	227,036	21,603	996,042	1,244,681	22,867	1,267,548	(104,753)	1,162,795			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,092,156	342,104	1,425,116	3,859,376		3,859,376	(89,174)	3,770,202			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Embassy Care Center, Inc.
0038711
COST REPORT RECLASSIFICATIONS
01/01/05
12/31/05

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	22,867	
2	FOOD		22,867

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX		
19	PROFESSIONAL FEES		

To reclass cost of appealing real estate taxes

Facility Name & ID Number Embassy Care Center, Inc. #0038711 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			39,541	39,541		39,541	104,226	143,767			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			68,167	68,167		68,167	(26,527)	41,640			32
33	Real Estate Taxes			70,066	70,066		70,066	8,263	78,329			33
34	Rent-Facility & Grounds			559,800	559,800		559,800	(559,800)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			737,574	737,574		737,574	(473,838)	263,736			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		99,320	138,683	238,003		238,003		238,003			39
40	Barber and Beauty Shops			1,986	1,986		1,986		1,986			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			93,623	93,623		93,623		93,623			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		99,320	234,292	333,612		333,612		333,612			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,092,156	441,424	2,396,982	4,930,562		4,930,562	(563,012)	4,367,550			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	18,556	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(357)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,269)	21		18
19	Entertainment	(865)	20		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(22,315)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(75,238)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (82,488)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(480,524)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (480,524)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (563,012)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS **Page 5A**

Embassy Care Center, Inc.

ID# **0038711**

Report Period Beginning: **01/01/05**

Ending: **12/31/05**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Veterans Expenses	$ (110)	10	1
2	Painting & Decorating	(1,114)	6	2
3	Deferred Mantenance	1,772	6	3
4	Bank Charges	(8,704)	21	4
5	Marketing Expense	(677)	19	5
6	Travel	(33,404)	25	6
7				7
8	From Embassy Building Partnership:			8
9	Trust Fees	(302)	20	9
10	Bank Charges	(398)	21	10
11	Non Patient Care - Interest Exp	(9,521)	32	11
12	R E Taxes	(4,026)	33	12
13	Mtgre Costs	(5,630)	32	13
14	Depreciation House	(3,846)	30	14
15	Depreciation - Section 754	(9,278)	30	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(75,238)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(357)	0	0	0	0	0	0	0	0	0	0	(357)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	4,552	0	0	0	0	0	0	0	0	4,552	5
6	Maintenance	658	0	10,836	0	0	0	0	0	0	0	0	11,494	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	301	0	15,388	0	0	0	0	0	0	0	0	15,689	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(110)	0	0	0	0	0	0	0	0	0	0	(110)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(110)	0	0	0	0	0	0	0	0	0	0	(110)	16
	C. General Administration													
17	Administrative	0	0	(249,442)	0	0	0	0	0	0	0	0	(249,442)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(677)	0	6,742	0	0	0	0	0	0	0	0	6,065	19
20	Fees, Subscriptions & Promotions	(1,167)	302	657	0	0	0	0	0	0	0	0	(208)	20
21	Clerical & General Office Expenses	(33,686)	416	156,475	0	0	0	0	0	0	0	0	123,205	21
22	Employee Benefits & Payroll Taxes	0	0	40,752	0	0	0	0	0	0	0	0	40,752	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(33,404)	0	4,135	0	0	0	0	0	0	0	0	(29,269)	25
26	Insurance-Prop.Liab.Malpractice	0	0	4,144	0	0	0	0	0	0	0	0	4,144	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(68,934)	718	(36,537)	0	0	0	0	0	0	0	0	(104,753)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(68,743)	718	(21,149)	0	0	0	0	0	0	0	0	(89,174)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Embassy Care Center, Inc. **#** 0038711 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	5,432	88,140	10,654	0	0	0	0	0	0	0	0	104,226	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(15,151)	(24,717)	13,341	0	0	0	0	0	0	0	0	(26,527)	32
33	Real Estate Taxes	(4,026)	4,026	8,263	0	0	0	0	0	0	0	0	8,263	33
34	Rent-Facility & Grounds	0	(559,800)	0	0	0	0	0	0	0	0	0	(559,800)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(13,745)	(492,351)	32,258	0	0	0	0	0	0	0	0	(473,838)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(82,488)	(491,633)	11,109	0	0	0	0	0	0	0	0	(563,012)	45

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Schedule	See Schedule		See Schedule		See Schedule	

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		34	Rent	$ 559,800	Embassy Care LLC		$	$ (559,800)	1
2	V		20	Licenses & Fees		Embassy Care LLC		302	302	2
3	V		21	Bank Charges		Embassy Care LLC		398	398	3
4	V		21	Trust Fees		Embassy Care LLC				4
5	V		32	Interest Expense		Embassy Care LLC		(30,332)	(30,332)	5
6	V		33	RE Tax		Embassy Care LLC		4,026	4,026	6
7	V		30	Depreciation		Embassy Care LLC		88,140	88,140	7
8	V		32	Amort Mtge Costs		Embassy Care LLC		5,630	5,630	8
9	V		21	Office		Embassy Care LLC		18	18	9
10	V		32	Interest Income				(15)	(15)	10
11	V									11
12	V									12
13	V									13
14	Total				$ 559,800			$ 68,167	$ * (491,633)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Management Fees	$ 349,042	Future Assoc		$	$ (349,042)	15
16	V	5	Utilities		Future Assoc		4,552	4,552	16
17	V	6	Maintenance		Future Assoc		10,836	10,836	17
18	V	17	Administrative		Future Assoc		99,600	99,600	18
19	V	19	Professional Fees		Future Assoc		6,742	6,742	19
20	V	21	Clerical and General		Future Assoc		156,475	156,475	20
21	V	22	Employee Benefits		Future Assoc		40,752	40,752	21
22	V	25	Auto Expense		Future Assoc		4,135	4,135	22
23	V	26	Insurance Expense		Future Assoc		4,144	4,144	23
24	V	30	Depreciation		Future Assoc		10,654	10,654	24
25	V	32	Interest Expense		Future Assoc		13,341	13,341	25
26	V	33	Real Estate Taxes		Future Assoc		8,263	8,263	26
27	V	20	License, Dues, Fees		Future Assoc		657	657	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 349,042			$ 360,151	$ * 11,109	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Haim Perlstein	Director	Administrative	22.96	None	40	100.00	Admin	$ 99,600	17-7	1
2											2
3	Nachshon Draiman	Director	Administrative	70.40	None	15	25.00	Finance			3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 99,600		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Future Associates
Street Address: 7514 N. Skokie Blvd
City / State / Zip Code: Skokie, Il
Phone Number: (847)982-1195
Fax Number: (847)982-0992

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Management Fees	888,687	2	$ 11,590	$	349,042	$ 4,552	1
2	6	Maintenance	Management Fees	888,687	2	27,590		349,042	10,836	2
3	17	Administrative	Direct allocation	888,687		297,600			99,600	3
4	19	Professional Fees	Management Fees	888,687	2	17,165		349,042	6,742	4
5	21	Clerical and General	Management Fees	888,687	2	353,510	315,793	349,042	138,845	5
6	22	Employee Benefits	Management Fees	888,687	2	100,196		349,042	39,353	6
7	25	Auto Expense	Management Fees	888,687	2	10,529		349,042	4,135	7
8	26	Insurance Expense	Management Fees	888,687	2	10,550		349,042	4,144	8
9	30	Depreciation	Management Fees	888,687	2	27,126		349,042	10,654	9
10	32	Interest Expense	Management Fees	888,687	2	33,966		349,042	13,341	10
11	33	Real Estate Taxes	Management Fees	888,687	2	21,038		349,042	8,263	11
12	20	License, Dues, Fees	Management Fees	888,687	2	1,672		349,042	657	12
13	21	Clerical and General	Per cent	100	2	50,371	50,371	35	17,630	13
14	22	Employee Benefits	Per cent	100	2	3,997		35	1,399	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 966,900	$ 366,164		$ 360,151	25

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	CIB Bank		X	Mortgage	$43,220.44	12/30/99	$ 4,510,000	$		9.7500	$ (36,435)	1
2	RE Taxes		X								16,190	2
3	Payroll Taxes		X								2,648	3
4	IDPA		X								9,363	4
5	Allocation from Future										13,341	5
	Working Capital											
6	State Financial		X	Working Capital						Various	32,739	6
7	CIB Bank		X	Working Capital						Various	(3,418)	7
8	Insurance		X								7,227	8
9	TOTAL Facility Related				$43,220.44		$ 4,510,000	$			$ 41,655	9
	B. Non-Facility Related*											
10	Interest Income		X								(15)	10
11	House		X								9,334	11
12	Adjust out House		X								(9,334)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (15)	14
15	TOTALS (line 9+line14)						$ 4,510,000	$			$ 41,640	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	126,005	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	8,263	2
3. Under or (over) accrual (line 2 minus line 1).	$	(117,742)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	196,071	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	78,329	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	56,677	8
	2001	60,323	9
	2002	63,352	10
	2003	63,005	11
	2004	66,066	12
Estimate based on 2004 bill adjusted to	67000		
2003 Bill	63005		
2004 Bill	66066		
Allocation from Future	8263		

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Embassy Care Center, Inc.
0038711
12/31/2005

Line 1 from 12/31/04	132259
Correct for related party paid tax	-6254
Corrected line 1	126005

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Embassy Care Center, Inc. COUNTY Will

FACILITY IDPH LICENSE NUMBER 0038711

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	03-17-36-300-010-0000	Nursing Home	$ 66,066.00	$ 66,066.00
2.	10-28-408-025	Management Office	$ 16,325.10	$ 1,822.00
3.	10-28-408-026	Management Office	$ 7,929.28	$ 885.00
4.	10-28-408-027	Management Office	$ 7,929.28	$ 885.00
5.	10-28-408-028	Management Office	$ 16,346.17	$ 1,824.00
6.	10-28-408-029	Management Office	$ 16,346.17	$ 1,824.00
7.	10-28-408-030	Management Office	$ 1,723.00	$ 192.00
8.	10-28-408-031	Management Office	$ 1,723.00	$ 192.00
9.			$	$
10.			$	$
		TOTALS	$ 134,388.00	$ 73,690.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? ☐ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☐ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☐ NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____
4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1993	$ 145,000	1
2					2
3	TOTALS			$ 145,000	3

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	171		1993		$ 2,363,000	$ 75,016	35	$ 67,514	$ (7,502)	$ 873,071	4
5											5
6	Alloc LCF			1986	85,361	3,414		2,846	(568)	54,299	6
7	Alloc LCF			1987	2,048	65	31.5	65		1,203	7
8											8
	Improvement Type**										
9	Various			1993	55,674	1,093	20	2,784	1,691	34,697	9
10	Various			1994	144,492	2,936	20	7,233	4,297	83,376	10
11	Various			1995	126,250	3,220	20	6,318	3,098	66,072	11
12	Various			1996	94,458	2,421	20	4,723	2,302	45,142	12
13	Various			1997	13,974	357	20	701	344	6,181	13
14	Various			1998	13,694	219	20	687	468	5,071	14
15	Various			1999	29,626	757	20	1,483	726	9,449	15
16	Various			2000	68,597	610	20	3,599	2,989	18,312	16
17	Various			2001	4,657	119	20	215	96	926	17
18	Alarm system			02/27/02	1,466	38	20	73	35	281	18
19	Exterior sewer connection			01/24/03	8,498	218	20	425	207	1,062	19
20	Rooftop Htg. Unit Module			02/24/03	768	20	20	38	18	96	20
21	Rooftop compressor unit			05/17/03	1,250	32	20	62	30	156	21
22	Hood suppression system			06/06/03	1,489	38	20	74	36	186	22
23	CCTV monitoring system			06/23/03	1,409	36	20	70	34	176	23
24	New roof			07/29/03	25,000	641	20	1,250	609	3,125	24
25	New roof			10/31/03	20,000	513	20	1,000	487	2,000	25
26	Plastering & Painting			11/12/03	8,052	207	20	402	195	805	26
27	Smoke detectors, door holders			11/28/03	805	21	20	41	20	101	27
28	Heat Exchanger			12/19/03	3,200	82	20	160	78	240	28
29	West wing toilet repairs			01/23/04	855	22	20	43	21	64	29
30	West wing sewer reairs			01/26/04	532	14	20	27	13	40	30
31	Voltage regulator tray			02/28/04	1,561	40	20	78	38	117	31
32	Broken water line			03/13/04	1,700	43	20	85	42	128	32
33	Clean outside manhole			04/14/04	1,413	36	20	71	35	106	33
34	Fire alarm service			05/05/04	1,658	42	20	83	41	124	34
35	A/C replaced roof compressor			05/20/04	3,410	87	20	171	84	256	35
36	Access control panel			05/21/04	1,205	31	20	60	29	90	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Tel & comp lines to network	05/21/04	$ 786	$ 20	20	$ 39	$ 19	$ 59	37
38	Inoized smoke detectors	05/21/04	1,163	29	20	58	29	87	38
39	Roof work	07/19/04	37,177	953	20	1,859	906	2,788	39
40	Replaced tranformer on rooftop unit	07/19/04	1,082	27	20	54	27	81	40
41	Ran E.M.T. and cables	08/02/04	846	22	20	42	20	63	41
42	Compressor	09/29/04	2,900	74	20	145	71	218	42
43	Repair exit door alarm;rooftop cam	12/01/04	1,287	33	20	65	32	97	43
44	Heat exchanger	12/01/04	1,658	42	20	83	41	124	44
45	Heat exchanger	12/01/04	1,732	44	20	87	43	130	45
46	Service door lock;control panel	01/01/05	1,835	45	20	46	1	46	46
47	Install electromagnetic door hldr	01/07/05	1,120	28	20	28		28	47
48	Svce on gate alarm;instl 2 wire	02/03/05	1,047	23	20	26	3	26	48
49	Heat Exchangers for A C	02/24/05	7,500	168	20	188	20	188	49
50	Locknetics 101 Plus door	03/09/05	3,461	70	20	87	17	87	50
51	Install wire push button cafe. door	06/09/05	751	10	20	19	9	19	51
52	Repalce compressors on A C	07/01/05	1,494	18	20	37	19	37	52
53	2 compressors	07/25/05	7,291	86	20	182	96	182	53
54	Fire alarm wiring	07/31/05	968	11	20	24	13	24	54
55	Sewer line	08/18/05	708	7	20	18	11	18	55
56	Replace kitchen Exhast fan	09/21/05	608	5		15	10	15	56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,161,516	$ 94,103		$ 105,483	$ 11,380	$ 1,211,269	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,161,516	$ 94,103		$ 105,483	$ 11,380	$ 1,211,269	1
2	Allocation from LCF	1987	11,748	373	31.5	373		6,806	2
3	Allocation from LCF	1988	660	21	31.5	21		363	3
4	Allocation from LCF	1989	245	8	31.5	8		127	4
5	Allocation from LCF	1993	6,824	175	39	175		2,163	5
6	Allocation from LCF	1994	10,405	267	39	267		3,056	6
7	Allocation from LCF	2001	2,898	74	39	74		333	7
8	Allocation from LCF-5 Ton Trane A/C	2002	710	18	39	18		62	8
9	Allocation from LCF-Office Remodeling	2003	431	11	39	11		21	9
10	Allocation from LCF-Electrical	2004	1,494	41	39	41		75	10
11	Allocation from LCF-Roof repairs	2004	194	Columns 5 to 9 included on line10					11
12	Allocation From Future	1987	37,024	1,176	31.5	1,194	18	22,556	12
13	Allocation From Future	1994	10,829	147	Var	147		6,790	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,244,978	$ 96,414		$ 107,812	$ 11,398	$ 1,253,621	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 273,219	$ 21,627	$ 27,416	$ 5,789	10	$ 175,832	71
72	Current Year Purchases	2,357	224	56	(168)	10	56	72
73	Fully Depreciated Assets	613,160	179	2,303	2,124	5/10	613,160	73
74								74
75	TOTALS	$ 888,736	$ 22,030	$ 29,775	$ 7,745		$ 789,048	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		BUS	6/16/1998	$ 1,200	$	$	$	5	$ 1,200	76
77		Dodge 2000 Caravan	4/7/2003	18,750	3,600	3,750	150	5	9,375	77
78		2001 Toyata Corolla	4/15/2004	7,370	1,474	737	(737)	5	737	78
79	Allocation from Future			90,620	1,693	1,693		5	53,727	79
80	TOTALS			$ 117,940	$ 6,767	$ 6,180	$ (587)		$ 65,039	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,396,654	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 125,211	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 143,767	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 18,556	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,107,708	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	House	$ 150,000	$ 3,846	$ 37,338	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 150,000	$ 3,846	$ 37,338	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description: (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 46,351	$		$ 46,351	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			293			293	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			80,574			80,574	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				97,546		97,546	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	39-2;39-3				11,465	1,774		13,239	13
14	TOTAL			$		$ 138,683	$ 99,320		$ 238,003	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Embassy Care Center, Inc. 0038711 01/01/05 to 12/31/05

Page16 Supplemnt

Special Services - Supplies - (Column 6 -Other)

1	Med Tube : Ent., & Urol	39-2	
2	Equipment Rental	39-2	
3	Non Routine Med Supplies	39-2	1774
	Total		1774

Outside Therapies (Column 5- Other)

1	Respiratory Therapy	39-3	
2	Lab & XRay	39-3	8880
3	Other Medical Expenses	39-3	2585
	Total		11465

STATE OF ILLINOIS

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/05 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,328	$ 4,680	1
2	Cash-Patient Deposits	54,651	54,651	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 110,000)	882,429	897,044	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	115,879	115,879	6
7	Other Prepaid Expenses	5,661	5,661	7
8	Accounts Receivable (owners or related parties)	2,453,381	3,456,385	8
9	Other(specify): Schedule	37,365	45,845	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,550,694	$ 4,580,145	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		149,058	13
14	Buildings, at Historical Cost		2,874,827	14
15	Leasehold Improvements, at Historical Cost	617,848	617,848	15
16	Equipment, at Historical Cost	415,114	807,114	16
17	Accumulated Depreciation (book methods)	(519,349)	(1,990,667)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	25,278	110,104	22
23	Other(specify): Schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 538,891	$ 2,568,284	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,089,585	$ 7,148,429	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,360,597	$ 1,810,928	26
27	Officer's Accounts Payable	1,402,678	1,402,678	27
28	Accounts Payable-Patient Deposits	49,584	49,584	28
29	Short-Term Notes Payable	339,468	684,050	29
30	Accrued Salaries Payable	178,201	178,201	30
31	Accrued Taxes Payable (excluding real estate taxes)	90,848	94,848	31
32	Accrued Real Estate Taxes(Sch.IX-B)	196,071	196,071	32
33	Accrued Interest Payable	54,059	54,059	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,671,506	$ 4,470,419	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		107,195	39
40	Mortgage Payable		3,479,521	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 3,586,716	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,671,506	$ 8,057,135	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 418,079	$ (908,706)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,089,585	$ 7,148,429	48

***(See instructions.)**

STATE OF ILLINOIS

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/05 Ending: 12/31/05

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES As of 12/31/05

OTHER CURRENT ASSETS:	Amount	Amount	OTHER CURRENT LIABILITIES:	Amount	Amount
Real Estate Tax Escrow	22,073	30,553	Accrued Expenses		
Employee Advances	2,774	2,774			
Insurance Escrows					
Repalcement & Repairs Escrows					
Deferred Federal Taxes	12,518	12,518			
	37,365	45,845			
OTHER NON CURRENT ASSETS:			OTHER NON CURRENT LIABILITIES:		
Construction In Progress					
Deposits	3,478	3,478			
Mortgage Costs	21,800	106,626			
Exchange					
	25,278	110,104			

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,874,068)	1
2	Restatements (describe):		2
3	Capitalize Embassy Partnership interco acct	2,249,309	3
4	Round Off Adj	3	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 375,244	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	42,835	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 42,835	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 418,079	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,787,065	1
2	Discounts and Allowances for all Levels	(220,210)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,566,855	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	241,842	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 241,842	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,733	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	68,659	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	22,169	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 92,561	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	**Prior Year Income**	107,408	28
28a	**Prior Year Expenses**	(35,269)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 72,139	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,973,397	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	868,109	31
32	Health Care	1,746,586	32
33	General Administration	1,244,681	33
	B. Capital Expense		
34	Ownership	737,574	34
	C. Ancillary Expense		
35	Special Cost Centers	239,989	35
36	Provider Participation Fee	93,623	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,930,562	40
41	**Income before Income Taxes (line 30 minus line 40)****	42,835	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 42,835	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/05

	DESCRIPTION	AMOUNT
1	Vending Commissions	
2	Adj of Prior period Expenses	
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,800	1,980	$ 54,763	$ 27.66	1
2	Assistant Director of Nursing	2,277	2,325	58,321	25.08	2
3	Registered Nurses	6,790	7,262	167,472	23.06	3
4	Licensed Practical Nurses	13,787	14,826	288,656	19.47	4
5	CNAs & Orderlies	59,590	62,908	609,581	9.69	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,405	4,781	62,386	13.05	8
9	Activity Director	3,084	3,474	32,030	9.22	9
10	Activity Assistants	7,577	8,377	66,852	7.98	10
11	Social Service Workers	5,140	5,563	77,600	13.95	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,758	23,844	219,368	9.20	15
16	Dishwashers					16
17	Maintenance Workers	3,032	3,392	29,067	8.57	17
18	Housekeepers	15,487	17,109	144,574	8.45	18
19	Laundry	7,304	7,584	54,450	7.18	19
20	Administrator	2,975	3,288	94,390	28.71	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,566	13,172	132,646	10.07	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	165,572	179,885	$ 2,092,156 *	$ 11.63	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	124	$ 6,172		35
36	Medical Director	Monthly	5,700		36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	600		39
40	Physical Therapy Consultant	Monthly	16,440		40
41	Occupational Therapy Consultant	12	630		41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	112	6,753		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	248	$ 36,295		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,282	$ 42,993	10-3	50
51	Licensed Practical Nurses	4,548	131,472	10-3	51
52	Certified Nurse Assistants/Aides	3,272	51,465	10-3	52
53	TOTAL (lines 50 - 52)	9,102	$ 225,930		53

Facility Name & ID Numbe Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/05 Ending: 12/31/05

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
PT and OT Salaries	1,722	1,730	$ 60,563	$ 35.01
	1,722	1,730	$ 60,563	$ 35.01

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Charlie Shorter	Admin		$ 2,500
Pearl Boulnois	Admin		62,298
Suzanne Glenn	Admin		29,385
Year end Accrual Adjustment			207
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 94,390

B. Administrative - Other

Description	Amount
Future Associates	$ 349,042
TOTAL (agree to Schedule V, line 17, col. 3)	$ 349,042
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Krupnick,Bokor, Kagda, & Brooks	Acctg	$ 10,750
L J Cohn	Acctg	14,654
R Peelo	Medicare Acctg	4,200
Sachnoff & Weaver	Legal	(4,335)
Personnel Planners	UC Cons	1,441
Ins Cons	Ins	5,100
First Bank	DM Legal	1,750
Various	Data Processing	16,522
Various	Marketing	677
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 50,759

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 111,887
Unemployment Compensation Insurance	23,288
FICA Taxes	157,614
Employee Health Insurance	28,642
Employee Meals	22,867
Illinois Municipal Retirement Fund (IMRF)*	
Employee Life Insurance	1,374
Holiday Expense	3,759
Allocation from Future	40,752
Other	28
TOTAL (agree to Schedule V, line 22, col.8)	$ 390,211

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,335
Health Care Worker Background Check	
(Indicate # of checks performed 93)	1,112
Dues and Subscriptions	192
Entertainment and Meals	865
Licenses and Fees	2,501
Allocation from Future	657
Less: Public Relations Expense	( )
Non-allowable advertising	(865)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,797

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	308
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 308

* Attach copy of IMRF notifications

**See instructions.

Page 21- Professional Services:

-

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	Painting & Decorating	6/02	$ 1,781	3	$ 297	$ 594	$ 593	$ 297	$	$	$	$	$
2	Painting & Decorating	6/03	690	3		115	230	230	115				
3	Painting & Decorating	6/04	3,178	3			530	1,059	1,059	530			
4	Painting & Decorating	6/05	1,114	3				186	371	371	186		
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 6,763		$ 297	$ 709	$ 1,353	$ 1,772	$ 1,545	$ 901	$ 186	$	$

Facility Name & ID Number Embassy Care Center, Inc. # 0038711 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,917** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **93,623**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **22,867** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **n/a**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm?
Firm Name: **No** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **n/a**
Attach invoices and a summary of services for all architect and appraisal fees.